USF HEALTH | TAMPA GENERAL HOSPITAL FETAL CARE CENTER

LOWER OBSTRUCTIVE UROPATHY REFERRAL

Please fax this form, sono report and prenatals to: (813) 821-8390.

TODAY'S DATE_____ /_____ /_____ **REFERRING DIAGNOSIS** _____

Patient's Last Name _____ First Name _____ Age_____

Patient's Home Phone_____ Cell _____Date of Birth _____ /_____ /_____

Gravida_____ Para _____ Ab _____ Living Children _____ GA _____ LMP _____ EDC _____

REFERRING PHYSICIAN_____**PHONE**_____

Address_____ Fax_____

City_____ State _____ Zip_____

Ultrasound Date	Right Kidney	Left Kidney
Renal Pelvis	mm	mm
Renal Parenchyma	☐ Normal ☐ Echogenic	☐ Normal ☐ Echogenic
Cystic Dysplasia	☐ No ☐ Yes	☐ No ☐ Yes

AMNIOTIC FLUID VOLUME Maximum Vertical Pocket _____cm AFI _____cm

BLADDER DIAMETER _____x _____x _____cm

KEYHOLE SIGN _____No _____Yes ASCITES _____No _____Yes

1. If a serum screen or non-invasive prenatal testing has been performed is there an increased risk for:

   Down's Syndrome? _____Yes _____No Neural tube defect? _____Yes _____No

   Others? _____Yes _____No

   Details_____

2. Has the patient undergone any diagnostic genetic procedures? _____Amnio _____CVS _____None

3. If a diagnostic genetic procedure has been performed, please provide: Date_____

   Results_____

If you have performed a vesicocentesis, please complete.

	Vesico #1	Vesico #2
Sodium (Na) < 100mEq/dl		
Chloride(Cl) < 90mEq/dl		
Osmolality(Osm) < 210mOsm/L		
Calcium(Ca++) < 8mEq/dl		
Beta2 < 10mg/l		
Protein < 20mg/dl		

OFFICE USE ONLY:
Date Received
Diagnosis
Recommendation
Follow Up

Thank you for your referral. We will get back with you as soon as possible.

e-mail: **fcc@tgh.org** · Phone (813) 821-9124 · Fax (813) 821-8390

Fetal Care Center

USF Health | TGH Tampa General Hospital